

Papulosquamous skin diseases

Type of scale

1. **psoriatic -type scale** (laminated silvery white scale) (easily seen تشوفه مباشره)
2. **pityriasis-type scale** (powder and fine ما تقدر تشوف
(الا لما تعمل كشط بالمشرط)
3. **lichen type scale** (tightly compact of surface so it is shiny ,translucent appearance)

Posriasis

Causes: idiopathic: may genetic or immun reaction

Provocative factor:

1. Trauma : koebner phenomenon
 2. Hypocalcemia
 3. Immunology
 4. Infection streptococci in form sore : in guttate psoriasis
 5. Drug : antimalaria- b-blocker - lithium
 6. Climate
 7. Psychology
 8. Endocrin- pregnancy
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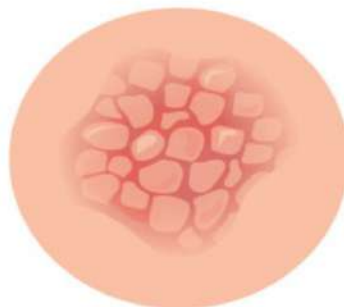


Primarily psoriasis Lesion: يحفظ عشان يطبق على الكل
sharply circumscribed erythematous plaque topped
by laminated silvery scales



Figure 3-1. Psoriasis vulgaris Primary lesions are well-defined, reddish or salmon-pink papules, droplike, with a loosely adherent silvery-white lamellar scale.

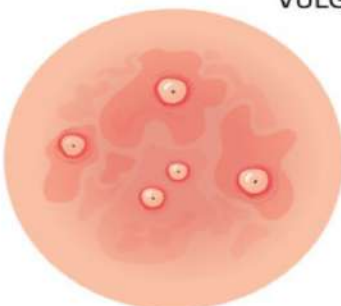
TYPES OF PSORIASIS



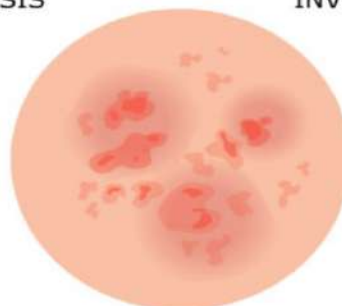
VULGAR PSORIASIS



INVERSE PSORIASIS



PUSTULAR PSORIASIS



GUTTATE PSORIASIS



PSORIATIC ERYTHRODERMA

1.chronic plaque psoriasis (psoriasis vulgaris)

Lesion: PRY (مذكور فوق)

- discoid (nummular),
- annular (produced by peripheral extension of lesion and central clearance,
- linear (Köebner phenomenon),
- geographic (curved lesions are confluent of large area as back)

DD = Tinea circinate + Hypertrophic lichen planus



Figure 3-4. Psoriasis vulgaris: chronic stable type Multiple large scaling plaques on the trunk, buttock, and legs. Lesions are round or polycyclic and confluent forming geographic patterns. Although this is the classical manifestation of chronic stable plaque psoriasis, the eruption is still ongoing, as evidenced by the small guttate lesions in the lumbar and lower back area. This patient was cleared by acitretin/PUVA combination treatment within 4 weeks.



Figure 3-3. Psoriasis vulgaris: elbow Chronic stable plaque psoriasis on the elbow. In this location, scales can either accumulate to oyster shell-like hyperkeratosis, or are shed in large sheets revealing a beefy-red base. This plaque has arisen from the coalescence of smaller, papular lesions that can still be seen on lower arm.

Auspitz Sign

Auspitz Sign:
Pin point Bleeding, Due to Removal
Of Scales from Psoriasis Plaque.

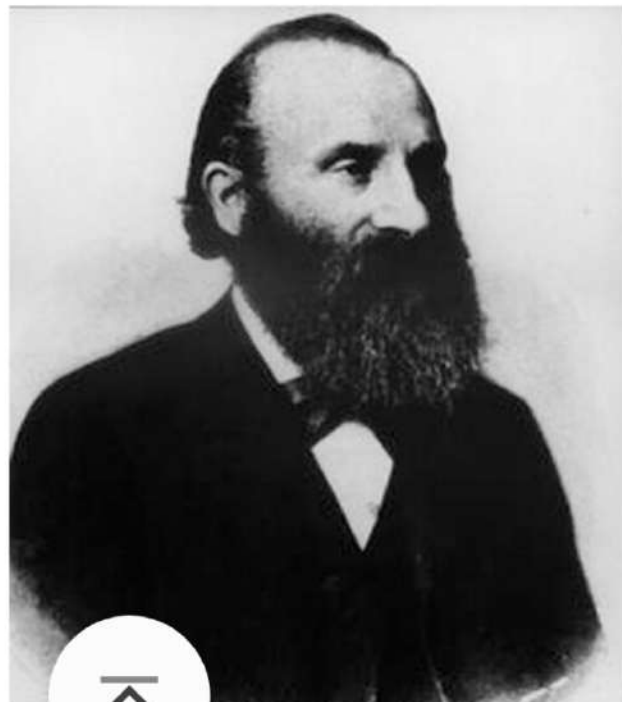
- It Confirms the Diagnosis of
Psoriasis.



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Koebner

D\D of Koebner Phenomenon:
1- Psoriasis.
2- Lichen Planus.
3- Vitiligo.
4- Wart.
5- Molluscum Contagiosum.



2.(guttate psoriasis)

Lesion: PRY (مذكور فوق) لكن هنا papule

Small rounded raindrop like Lesion

Causes: مهمه (streptococcal) الوحيدة

DD: Pityriasis rosea



Figure 3-2. Psoriasis vulgaris: buttocks (guttate type) Small, discrete, erythematous, scaling, papules that tend to coalesce, appearing after a group A streptococcal pharyngitis. There was a family history of psoriasis.

3.(scalp psoriasis)

Lesion: **PRY**(well -defined Erythematous SCALY intact hair single or diffuse plaque)

Differential DIAGNOSIS

Scalp psoriasis	Seborrheic dermatitis
Scales white No yellow	Scale yellow
DRY جاف	Greasy دهني
SHINY براق -لامع	Lusterless كامد- عديم اللمعان



Figure 3-9. Psoriasis, facial involvement Classic psoriatic plaque on the forehead of a 21-year-old male who also had massive scalp involvement.



Figure 3-8. Psoriasis of the scalp There is massive compaction of horny material on the entire scalp. In some areas, the thick asbestos-like scales have been shed revealing a red infiltrated base. Alopecia is not due to psoriasis but is androgenetic alopecia.

4.(flexural psoriasis) (Inverse psoriasis)

Lesion: PRY(المذكور فوق) (scaly decrease or no appear بسبب → moisture and continuous friction

Differential DIAGNOSIS : Fungal infection +atopic and seborrheic dermatitis)



Figure 3-10. Psoriasis vulgaris: inverse pattern Because of the moist and warm environment in the submammary region, scales have been macerated and shed revealing a brightly erythematous and glistening base.

5.(nail psoriasis)

Lesion: - pits on nail plate

- Onycholysis (separation of nail plate from bed)

- Subungual hyperkeratosis

- Oil drop (salmon patch)

DD: nail Fungal infection



Figure 3-11. Psoriasis of the fingernails Pits have progressed to onycholysis (holes in the nail plates), and there is transverse and longitudinal ridging. This patient also has paronychia, psoriasis, and psoriatic arthritis (for further images of nail involvement, see Section 34).

Salmon patch



6.palmoplantar psoriasis)

Lesion: (- red erythematous)(-dry-thickness)-
(fissure - well defined scaly)



Figure 3-7. (A). Psoriasis, palmar involvement The entire palm is involved by large adherent scales with fissures. The base is erythematous and there is a sharp margin on the wrist. **(B) Psoriasis vulgaris: soles** Erythematous plaques with thick, yellowish, lamellar scale and desquamation on sites of pressure arising on the plantar feet. Note sharp demarcation of the inflammatory lesion on the arch of the foot. Similar lesions were present on the palms.

Severe clinical Type psoriasis

1. pustular psoriasis

Lesion (sterile pustules)



Figure 3-12. Palmar pustulosis Creamy-yellow pustules that are partially confluent on the palm of a 28-year-old female. Pustules are sterile and pruritic, and when they get larger, become painful. At the time of this eruption, there was no other evidence of psoriasis anywhere else on the body, but 2 years later the patient developed chronic stable plaque psoriasis on the trunk.

2.Arthropathic psoriasis

- oligo or poly articular -sacroiliac and distal interphalangeal joints most site

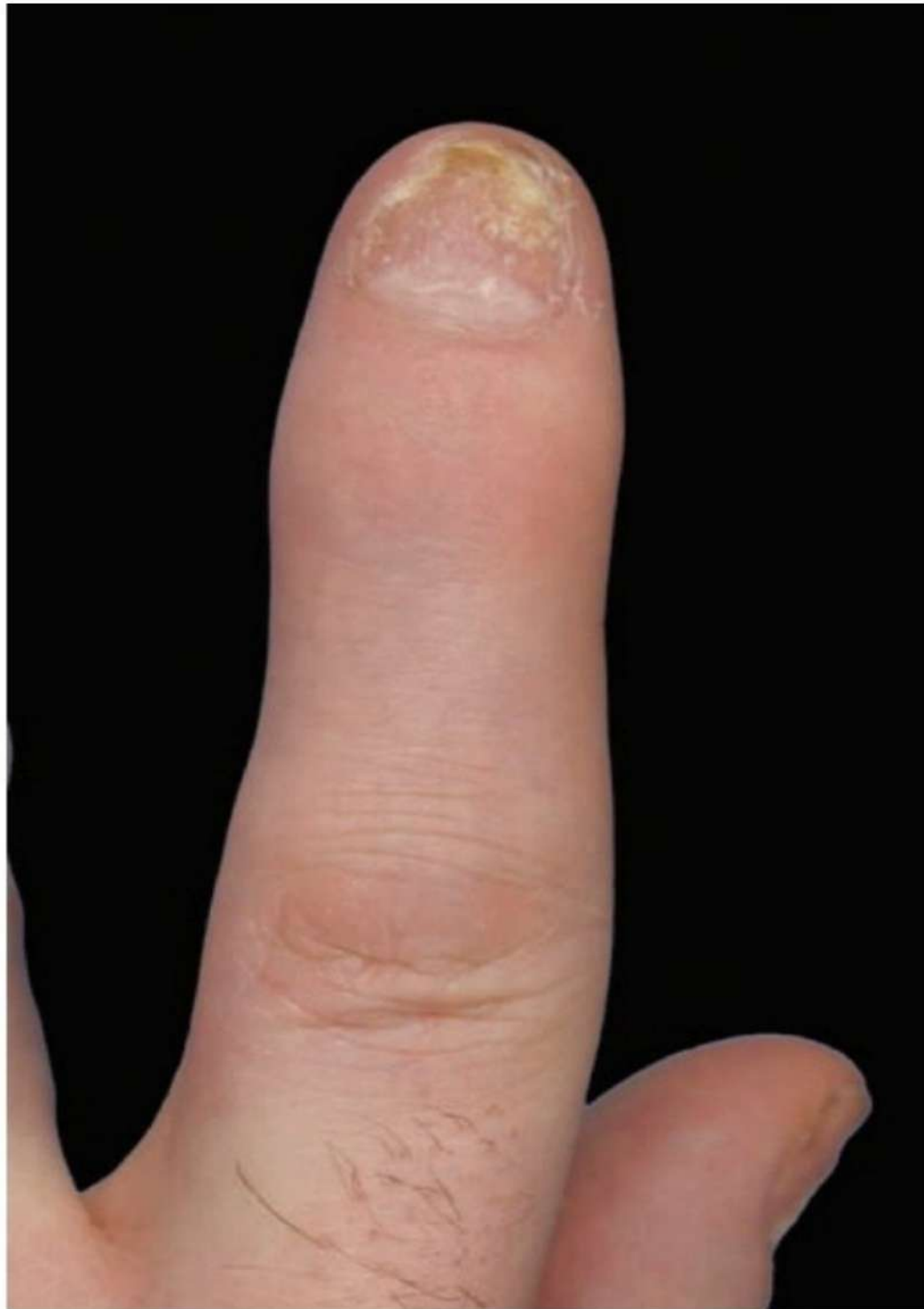


Figure 3-15. Psoriatic arthritis Dactylitis of index finger. Note sausage-like thickening over interphalangeal joints. There is psoriasis of the nail.

3.Erythtodermal psoriasis

Lesions extensive generalized erythema of entire surface with few scale

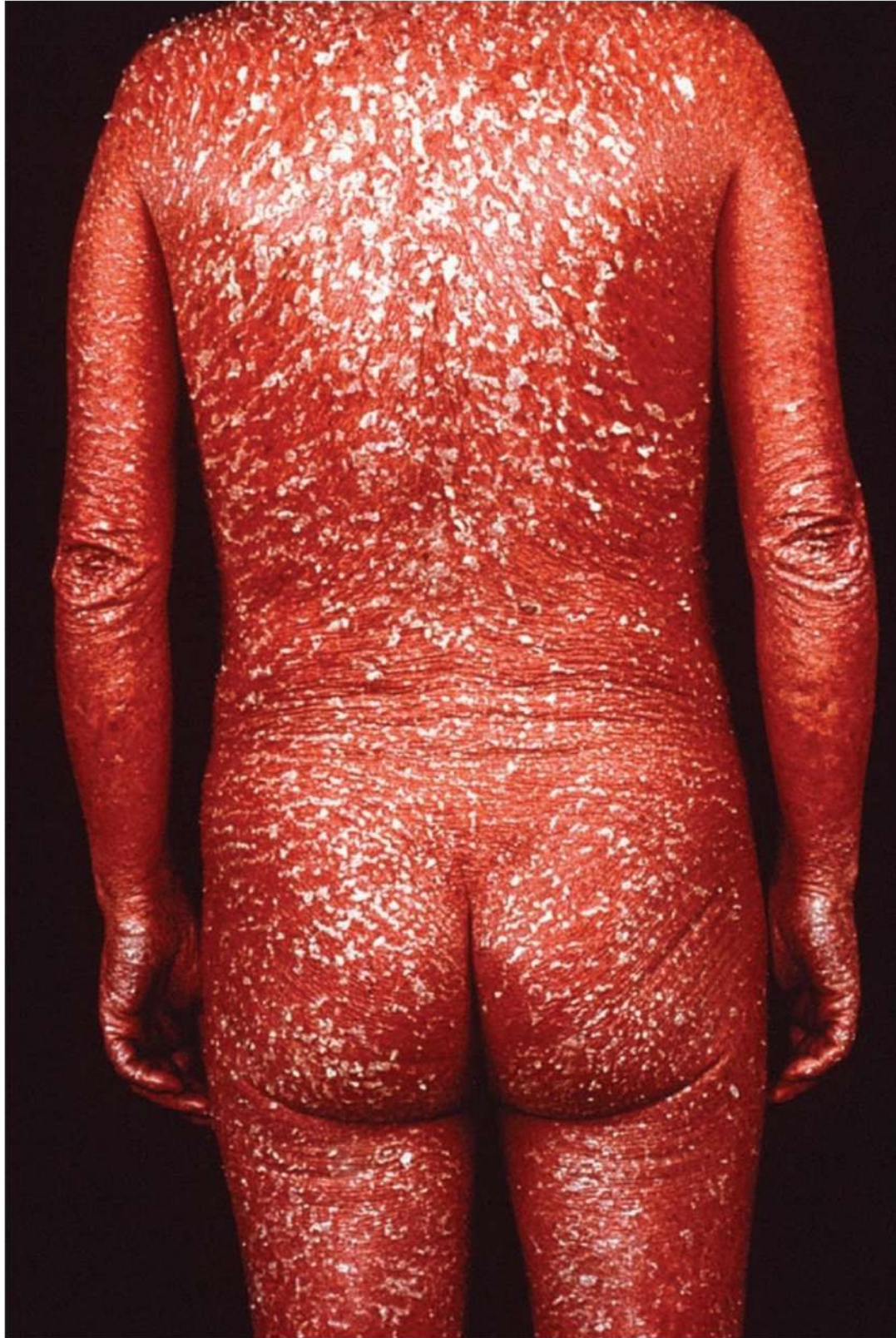


Figure 8-1. Exfoliative dermatitis: psoriasis There is universal erythema, thickening of the skin, and heavy scaling. This patient had psoriasis as suggested by the large silvery white scales and the scalp and nail involvement not seen in this illustration. The patient had fatigue, weakness, malaise, and was shivering. It is quite obvious that such massive scaling can lead to protein loss and the maximal dilatation of skin capillaries to considerable heat dissipation and high-output cardiac failure.

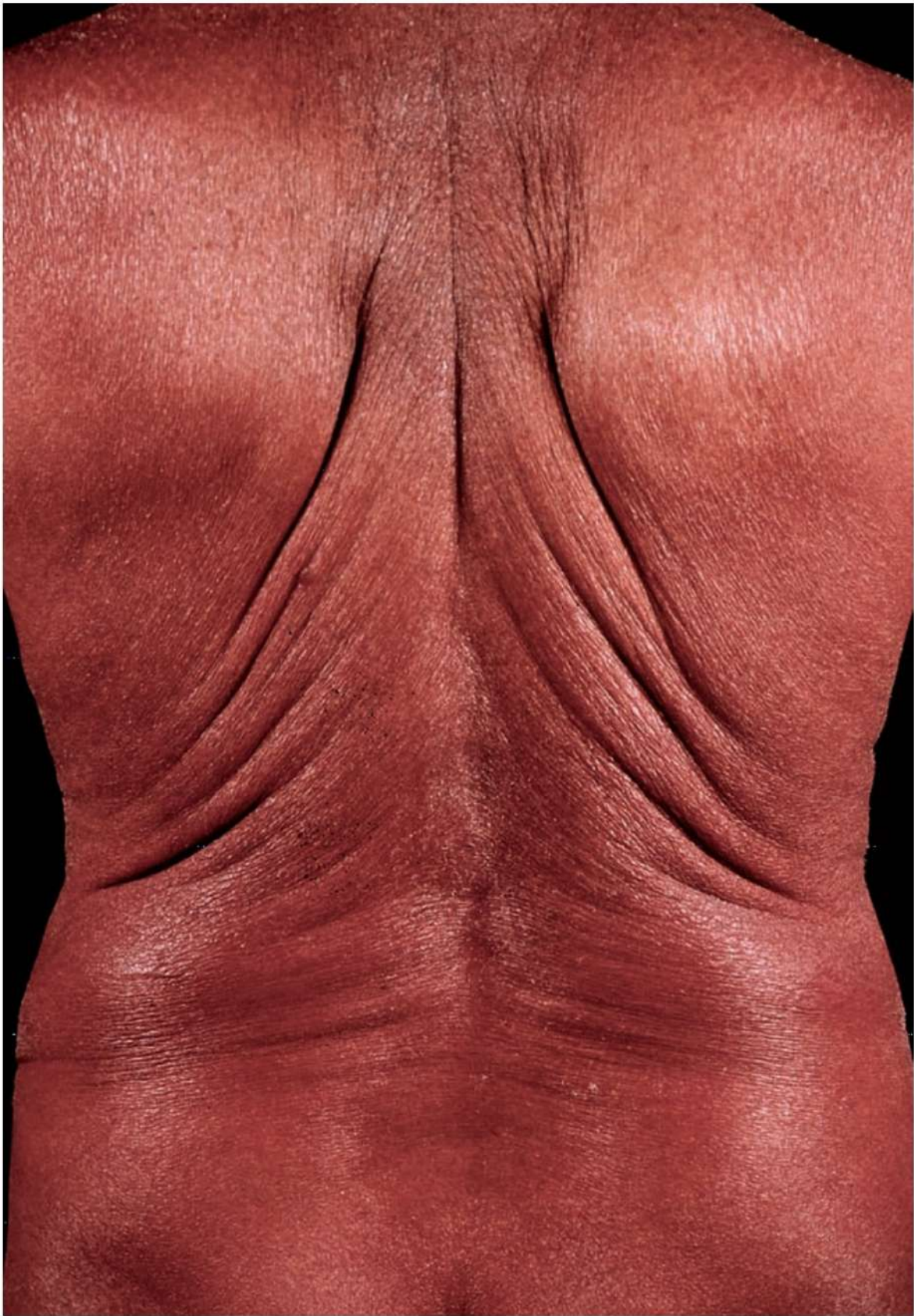


Figure 8-2. Exfoliative dermatitis: drug induced This is generalized erythroderma with thickening of skin resulting in increased skin folds, universal redness, a fine brawny scaling. This patient had developed erythroderma following the injection of gold salts for rheumatoid arthritis.



Figure 8-3. Exfoliative dermatitis: cutaneous T-cell lymphoma There is universal erythema, thickening, and scaling. Note that in contrast to erythroderma shown in Figs. 8-1 and 8-2, the degree of erythema and thickness is not uniform and the redness has a brownish hue. In addition, this elderly patient had hair loss, massive involvement of palms and soles with diffuse hyperkeratoses, cracks, and fissures. Generalized lymphadenopathy was also present.

Treatment of psoriasis:

1. Topical treatment:

- Emollients to minimize scaling, preferably applied twice daily.
- Keratolytics to remove the scales, e.g. salicylic acid preparations 2%-5%.
- Tar preparations: Crude coal tar ointment 2%-5% appears to have an antimitotic effect and thus slows down the excessive rate of keratinocyte division. Dithranol (anthralin) has the same action as tar preparations. It is highly effective but irritating and stains the skin brown. The patient can be given a tar bath, followed by exposure to UVB, then dithranol paste 0.1% (Ingram technique).

Both tar preparations and dithranol are contraindicated in pustular and erythrodermic psoriasis and in sensitive areas as face, genitalia and flexural areas.

- Topical steroids, with or without occlusion; mainly for localized areas only. The benefits should be weighed against the side-effects. Intralesional corticosteroids are useful for nail psoriasis.
- Vitamin D3 analogues, e.g. calcipotriol ointment (Daivonex®). They are thought to act via normalizing epidermal differentiation. They are effective but expensive. They may cause irritation or hypercalcemia if the maximum dose is exceeded.
- Topical retinoids, e.g. tazarotene gel (Zarotex®).
- Combinations therapy of topical preparations e.g. Steroides and salicylic acid.

2. Phototherapy:

- UVB (narrow-band or broad-band):
It can be given 3 times weekly until clearance followed by maintenance sessions, or repeated exposure to sunlight. UVB is believed to inhibit epidermal mitosis. Goeckerman regimen involves the use of both topical tar and UVB.
- Photochemotherapy with PUVA (psoralen plus UVA):
It involves the use of an oral photosensitizing agent as psoralen, with subsequent total body exposure to UVA 2 hours later. Long-term risk of skin cancer is the major concern.
- Recently, excimer 308nm laser can be helpful for selected cases. [excimer]

3. Systemic treatment: MAC

Indications include: generalized erythrodermic or pustular psoriasis, arthropathic psoriasis, extensive plaque psoriasis covering a large surface area of the skin, or significant psychologic distress because of the disease.

- Methotrexate (Methotrexate®), a folic acid antagonist: methotrexate → Hep.
Its main side-effect is hepatotoxicity. The dose is 0.2-0.4 mg/kg/week. It has an antimitotic effect, decreasing the rate of division of basal cell layer.
- Retinoids, e.g. etretinate (Neotigason®) or acitretin (Acitretin®): AC: Retin +
They are synthetic derivative of vitamin A (Vitamin A is necessary for normal keratinization). They are particularly useful in pustular, erythrodermic or extensive psoriasis. The dose is 0.5-1 mg/Kg/day. The main side-effects are teratogenicity, and hyperlipidemia. *Pregnancy should be avoided during treatment and for 2 years after end of treatment course.*
- Cyclosporine (Neoral®): Cyclosporine → immunosuppressant - safe
It is an immunosuppressive drug. It is particularly used in arthropathic psoriasis. The dose is 3mg/Kg/day. Its main side-effects are hypertension and nephrotoxicity.
- Combined therapy, e.g. Re-PUVA (etretinate combined with PUVA).
- Recently, the newer biologic agents are useful but very expensive, e.g. tumor necrosis factor inhibitors.